

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011694

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1705

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 1 1963

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>6 Mo</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lakeside Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>5212 Byram Ford Rd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PEGGY</b> Middle <b>SUE</b> Last <b>INGRAM</b>		4. DATE OF DEATH Month <b>3</b> - Day <b>15</b> - Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-31-1962</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	
11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Robert Ingram</b>		13b. MOTHER'S MAIDEN NAME <b>Helen White</b>	
14. NAME OF HUSBAND OR WIFE <b>Robert Ingram</b>		Address <b>K. C. Mo. 5212 Byram Ford Rd.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT <b>Robert Ingram</b>		Address <b>K. C. Mo. 5212 Byram Ford Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest -</b> DUE TO (b) <b>Pulmonary edema - Congestive heart</b> DUE TO (c) <b>Pneumonitis - defect -</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>[REDACTED]</b> a.m. <b>[REDACTED]</b> p.m. <b>[REDACTED]</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Carrollton, Missouri</b>	
21. I attended the deceased from <b>Birth</b> and last saw him alive on <b>3/15-63</b>		Death occurred at <b>11:20 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>James E. Griffin</b>		22b. ADDRESS <b>3900 Paces 14C Mo</b>	
22c. DATE SIGNED <b>3/16/63</b>		22d. LOCATION (City, town, or county) (State) <b>Carrollton, Missouri</b>	
23a. BIRTH, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3-17-1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Carrollton, Missouri</b>	
24. FUNERAL DIRECTOR <b>Sheil Funeral Home, Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3-16-63</b>	
26. REGISTRAR'S SIGNATURE <b>Auth Long</b>			

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

VS 300 Rev. 4/59

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DOCUMENT

BY AFFIDAVIT OF James E. Griffin, Medical Certification

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_

Student Embalmer No. 656

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4954

P. O. Address R. P. Miller

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.